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Effect of Equity Financing Strategy on Service Quality; Does Bed Capacity Matter; Evidence from Healthcare Providers in Kenya

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Abstract

The purpose of this study was to establish the moderating effect of bed capacity on the relationship between equity healthcare financing strategies and the delivery of quality healthcare services in Kenya. The target population being senior management and the clients drawn from 535 level 4 to 6 hospitals in Kenya. Random sampling was used to select a sample size of 242. Findings from Hayes Model 1 showed that bed capacity showed significant moderating effect on the relationship between equity financing and service quality ($R^2\Delta$=.091, β=.348, $p<0.05$). The study concludes that equity financing enhances delivery of quality service in hospital with high bed capacity. Further, government owned hospital with high bed capacity increase use of equity debt financing strategies in improving service quality delivery. The study provides unique knowledge on hospital financing in relationship to service quality. In addition, the study has contributed to new knowledge by indicating moderating effect of hospital bed capacity on financing strategies-service quality relationship.

Keywords: *Equity Financing, Delivery, Service Quality, Hospital, Bed Capacity & Kenya*

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1.1 Introduction

Care quality as the extent to which health facilities for persons and communities contribute to the probability of intended healthcare results that correspond to the present expert insight are very critical (WHO *et al*, 2018). As attested by Gill, (2009), high performance within the service industry is majorly reliant on the integrity of their provisions since it plays a role in firm's combativeness as well as client satiety (p. 533).

Quality management should therefore be a fundamental element of service companies' effectiveness. A particular illustration of the service sector that acknowledges the essence of quality as an aspect of healthcare is the field of medicine. Globenko & Sianova (2012) contend that administering quality in the field of medical care is an arduous undertaking due to its intricateness. An analysis conducted in Iran ruled that Quality in healthcare is as a result of collaboration between the healthcare professional and the patient in a commendatory surrounding.

Quality in healthcare provision is reliant on individual aspects of the healthcare service benefactor and the patient as well as aspects relating to the healthcare institution including the wider surrounding. According to Mohammad, (2014), care quality and patient results are influenced by discrepancies in internal and external elements like availability of monetary assets coupled with correspondence and partnership among benefactors. In support of this notion, Mosadeghrad, (2014) conducted a research on elements that impact service quality and concluded that the economic status of a patients may impact the quality of healthcare provisions. He made an inference that in some cases, the patient lacks the money to meet the expenses of treatment and in turn opts out of the procedure. In case of lack of adherence to doctor's instructions as a result of monetary issues, the treatment will be unsuccessful. In corroboration to this Acharya, *et al*, (2017) stated that most people in Africa go without health care from which they could benefit greatly especially the poor who may not be able to afford healthcare in private hospitals.

The privilege of obtaining provisions for persons and families in Kenya is contingent on their financial capability. This goes to say that, those with inadequate funds to get them basic healthcare fail to get treatment since the level of care offered is determined by the money one can cough out in exchange for such services. This observation has been supported by a study done on financing health in low-income countries whereby after the Government of Uganda decided to abolish the user charges, the result was that there was an impact on the poor's use of services in public health sector facilities. Indeed, the more rigorous studies showed that the benefit incidence in public facilities after abolition improved. Whereby, utilization by the poor increased relative to the utility by the non-poor (World Bank, 2005). Mosadeghrad, (2014) in a study done on factors influencing healthcare service quality, established a number of factors affecting service quality to include financial resources and partnership development. It has also been established in another study that developing economies, medical care delivery system has inadequate; equipped medical staff , furthermore there is an insufficiency in the supply of medication; going by Economist Intelligence Unit, (2012), there is defective acquisition and dispensation frameworks that contribute to disproportionate healthcare access.

According to Sorensen, *et al*, (2015), medical care delivery is hugely intricate and a number of countries globally use up a significant amount of assets in an effort to deliver it. Very little success has been seen in enhancing the service quality in public health centers, this is worsened by inadequate information on the fundamentals affecting the provision of quality service within the public health department, despite directives been taken to rehabilitate the situation. As such, it is

critical to determine other implicit aspects that possibly impact the quality of service as pertaining to medical care other than money. Three sources of funding for the health sector have been illustrated by global works, they include, private, public and quasi-public sources. Nonetheless, Irinoye *et al*, (2014) suggests that there are significant discrepancies throughout pertaining to the way in which funds are obtained from the aforementioned sources as well as the role played by each one in the inclusive sponsorship of medical care. Based on Munge & Briggs, (2014), medical care in Kenya is sponsored through; health insurance (social, community based and private), tax revenues (Ex-chequer) and out of pocket payments (user fee).

Problem Statement

Okech and Gitahi, (2013) observe that funding the public health service delivery within Kenya has proved to be a huge challenge, pushing the national authorities to change from conventional techniques of funding medical provisions to a modern framework of user charges in public health institutions. Subsequent to past deliberations on appraisals of how much money is required to sustain medical care within Kenya and the various sources of capital necessary, there has been wide discussions on accurate levels of donations from these sources with little consensus on the issue (Carrign, 2014). Recently, other concern areas have revolved around the devolution of funds to healthcare and precise contributions by the government to health care activities to increase the level of health care service delivery in the country (Kimani, 2012). Despite the changes brought about by the devolved systems of government as per the Constitution of Kenya, (CoK, 2010), its impact on service quality are yet to be felt. This situation has therefore prompted the necessity to establish the role played by other factors such as institutional characteristics on financing strategies of service quality.

A look at the literature shows that although there have been studies on healthcare financing and quality of services, there is paucity of data on what role the bed capacity and different funding source play in moderating provision of service quality. It is therefore against this background that the study sought to investigate the moderating effects of bed capacity on the relationship between financing strategies on the delivery of quality healthcare services in hospitals in Kenya.

H_1: *There is no moderating effect of hospital bed capacity on the relationship between equity financing strategies and quality of healthcare service in Kenya.*

1.2 Theoretical Framework

In order to fully understand financing, an appreciation of the finance theories that have shaped financing over the years is important. The study is anchored on capital structure theories (Modigliani miller theory; trade off theory and pecking order theory). The capital structure theories entail the Modigliani Miller Theory (MM Theory), The Tradeoff Theory, Pecking Order Theory and Agency Cost Theory. These theories have general assumptions and specific assumptions to each of the theories. According to Milton & Raviv, (1991),the general assumptions of these theories are that: Only two sources of capital exist: equity and debt, the total resources of the firm are predetermined and do not fluctuate, the total funding stay constant, the level of expediency can be adjusted by the firm either by putting shares up for sale and retiring debt or by issuing debt and reclaiming equity, operating revenues (EBIT) are not speculated to increase, all the stakeholders are thought to hold similar considerations about future turnover, enterprise

contingency is steady over time and though to be impartial to its investment structure and financial contingency, the establishment has perpetual existence, corporate tax is unheard of and that the dividend payout ratio is 100%.

The Trade-off school of thinking acknowledges that debts and equity form the capital accumulated by companies, according to the theory, there is a merit of debt funding as a result of its tax benefits, nonetheless some expenses are incurred due to bankrupt, non-bankrupt and debt costs. The theory continues to establish that the marginal advantage of debts reduces as the level of debts and concurrently the marginal cost of debts rises as the debts rise, as such a reasonable company will advance by the tradeoff point to establish the degree of equity and debts to fund its activities (Chen, 2015).

In mercantile finance, pecking order model suggests that the cost of funding heightens with disproportionate information. Funding is obtained from three sources, new equity, internal funds and debt. Firms give precedence to their funding sources, the first preference falling on internal funds, followed by debt after which increasing equity comes in as a final resort. Thus, internal funds are used prior, when they get exhausted, the debt is taken up; finally when no more debt can be issued, the equity is then issued. This notion stresses that establishments stick to a tier of funding sources and lean more on internal funding when it exists and debt comes before equity when external sponsorship is concerned (equity would require issuing of holding which translates to 'welcoming external ownership' into the firm. Thus, the form of debt a firm chooses can act as a signal of its need for external finance.

2.1 Equity Financing Strategies and Service Quality

In publications equity financing strategies have been elaborated as the sale of ownership shares in an effort to increase capital for running the establishment. Daniel et al., (2010) attests that equity financing is an enterprise capital financing technique that doesn't call for payback and neither bears interests on money raised, it however gives stakeholders a sort of proprietorship in the establishment. Kongmanila and Kimbara, (2007) explain that the aforementioned funding technique can also entail a source of investment, property of the omission donations of the Board, deferred income, the contribution of partners, and income flows of the establishment. On the other hand, Rosli *et al*., (2010) elaborates that sources of debt funding is a technique of debt money that entails interest-linked tools and is made up of several reserves for instance secured loans, family/acquaintance loans, credit cards bank loans and other forms of credit (Fraser, 2005).

Some of the deciding factors that might drive hospitals to explore equity financing include cases where a hospital's creditworthiness is an issue; in cases where hospitals are confident that they could generate a healthy profit margin and the hospital ease of sharing decision making with equity partners. Cited advantages of equity financing are the less burden of paying debts providing opportunities to channel more money to grow the hospital, forgotten credit issues, and opportunities to learn and gain from partners. Some of the well-known and well-researched equity financing strategies include funding through ex-chequer and cost sharing mechanisms.

It is a recommendation by experts like Awunyo-Vkor and Bacln (2012) to depend more on capital that is raised within the establishment that when assessing equity financing and firm success. Lavorsky, (2013) plays a huge role in scientific works through rejecting the free cash flow or otherwise the tractor off hypothesis and standing by the peccary order model. In their study, Audu and Anafi (2013) employed a panel data technique demonstrating a definite correlation between

equity financing and its profitability of a loss of banks within Ghana stock exchange as from 2005 to 2012 using the equity finance as its core. The research thereafter supported the complete optimization of reserves at their command in a bid to raise lucrativeness in the Ghana listed bank. According to Akeem, Terer, Kiyanjui and Kayode (2014) the impact equity finance has on the companies effectiveness is unfavorable which proxies by the return on the investment and on the return on asset. Recommendation where made that the organization should adopt less debt and more equity while financing the business activities, also establishment of an organization to point that the weighted average cost of capital is minimal.

Other studies on equity financing and organization performance reveals the Proof of mixed relationship Olokoyo (2012) reveals that an organization equity finance in terms of leverage have a significant negative relationship with the market performance measure (Return On Assets) and that the equity finance measure have a positive and highly significant relationship with the market performance measure (Tobin's Q). The study established that Nigeria Organization are partially financed by equity capital or a mix of equity capital and short term debt. The study reveals that the maturity structure of debt affects the performance of organization and also the size of the organization has significant positive effect on its performance.

Velnampy and Niresh (2012) reveal a negative relationship between equity finance and profitability except the association between significantly negatively correlated with net internet margin, debt to the total fund is found to be significant negatively correlated with the net profit and net interest margin. It was revealed by the author that the outcome of the study was to guide organisation, lead creditors and policy planers to formulate better capital structure, better equity financing and capital structure policy decision. Hassan, Alisan, Rahman and Alamu (2014). The results also reveal a significant negative effect of equity finance on (ROA). However, there wasn't a concrete evidence of an effect on the equity finance on organization performance as measured by ROE and Tobin's Q. There was also conclusion that equity has a negative impact on the organization performance. The hypothesis pecking order was also consistence on the empirical studies, turned out to be inconclusive. It is a bit ambiguous, maybe due to the theoretical framework difference and the method of its estimation. Some researchers have over-emphasized on the models which include the control of variable e.g age and size of the organization. Also there factors are known to influence the organization performance and can't be classified or referred to as one of the element of equity financing.

2.2 Equity Financing, Bed Capacity on Service Quality

Most of the studies on hospital characteristics are not keen in analyzing the interactive effects of such characteristics on patient satisfaction and service quality. In Kenya, there is no single study by year 2017 that has focused on bed capacity as a moderating factor on service quality. The paucity of data was important in driving the inquiry process on moderating effects of bed capacity on hospital service quality.

As observed by Compton, *et al.*, (2014), hospital characteristics entail the elements in one medical center that set it apart from another. The numbers of beds that are present within the health center since it started running also fall under this category. A variety of nations are shifting to planning that is dependent on service capacity and operation. Based on 4-6 Andrews, & Bonta, (2014), the proportion of beds per demography and bed retention persist as primary indicators of hospital scope planning.

While Bed volume remains the metric of preference when it comes to planning sanitarium care as well as delivery of service, there exist numerous issues linked with this strategy. Of significance is the fact that the number of beds or bed retention fail to offer an accurate estimate of the provisions availed in health centers, considering the huge discrepancy in case mix and therefore the cost of caring for those filling the beds, nor are they appropriate in speculating future needs. The metric suggests the bed to be the chief element of capital reservoir in the health center, undermining the efficiency of the other resources in its environs. The almost worldwide trend of increasing volume of day contingents coupled with briefer stays in hospital goes on to disqualify beds as a metric of volume. Furthermore, the persistent use of "Bed numbers" doesn't acknowledge the dispositions and correspondences from venturing into various sorts of health endowment. Therefore, according to Sheetz, Dimick, & Ghaferi, (2016), while bed capacity holds the advantage of propriety given that they are one of the few metrics of volume within health centers that are constantly gathered, there is an increasing acknowledgement of the fundamental demerits of this indicator. Etzioni, *et.al*. (2014) opines that diagnosis-linked clusters are not a fitting strategy for capacity planning either, but a technique of classifying admissions, obtained from traditional micro-costing data and integrating diagnosis and any actions. This goes to show that they are essential in computing costs, however they offer little insight on the combination of wherewithal that is required.

Reducing the occupancy period and clearing of beds in health centers is a show of cost reduction. Nonetheless, it is challenging to compute the scope of such cost saving and is certainly reliant on several aspects. The potency of beds in health centers can be presented in two criteria; The first being the efficacy they bear with regards to meeting the desired results in line with the investment, whereas number two is the expense incurred by the health center when managing the account costs of beds(coined by the WHO as the hotel cost). Past assessments on cost-effectiveness mostly employed accounting cost as an alternative to it. This is majorly due to its simplicity when it comes to computing and deciphering it, particularly by managers within health centers. Herrin, *et al* (2015) opined that a faculty in a hospital may experience a case where patients are rejected due to maximum bed occupancy and in turn the complimentary medical provision is pushed forward because of the shortage of beds. Mismanagement of assets as well as scarcity in monetary reinforcement usually leads to such scenarios. On the contrary, an irrational medical service time or excess supply of hospital beds is indeed a waste of existing limited assets

3.1 Material and Methods

The study adopted positivism holds that there is always a cause leading to effect. An explanatory survey research was adopted for this study. The study is associated with experiments and surveys where quantitative data is the norm (Yin, 2003). Analysis methods using statistical and mathematical procedures were used and conclusions drawn to help answer the research questions. An explanatory survey research was adopted for this study. It is the initial research into a hypothetical or theoretical idea. The design is usually applicable in settings where a researcher has an idea or has observed something and seeks to understand more about it. The design was appropriate for this study and was helpful in laying the groundwork that will lead to future studies (Combo & Tromp, 2006). To overcome any possible limitations, hospitals and patients were selected as randomly as possible and across different counties for representation. The three senior management officers and one client/patient receiving services at the hospital at the time of the interviews were the target population. With 4 respondents drawn from each of the 242 hospitals, a total of 968 respondents were expected. The targeted hospitals comprised of public, private and

faith-based across the country falling between level 4 and level 6. The target population had the appropriate information on the constructs of the study given that their managerial roles in the running of the hospitals and the position of the client as the receiver of services. Lower level facilities were excluded from the study given the volume of patients they receive and the level of care and services they are able to offer with their capacity.

The study employed simple random sampling of the hospitals and selection of client/patients participants as well as sampling the 29 members of top management with information relevant to the study. Using above Slovin's formula, a sample size of 233 hospitals was selected from a population of 535 level 4 to 6 hospitals in Kenya. The inflation of the numbers from 233 to 242 was meant to take care of the non-responses. This represented 3.9% more hospitals in Kenya at sample size inflation of 4% as recommended by Stoop (2005) stating that the inclusion of extra number of unit of analysis is always critical in maximizing the contact in this case, number of hospitals. Primary data was collected from the respondents of the study using the designed data collection instruments distributed in the hospitals. Data was collected using structured questionnaire, which served as the most appropriate instruments. The sampling frame of the study was the list of registered level 4, level 5 and level 6 hospitals in Kenya. Hospitals were selected randomly in the study. To select health worker in the hospital stratified random sampling based on departments was used. Individual health workers in each department were randomly selected. This departments included; finance and administration department, the clinical services department, and the nursing departments provided a sampling frame for the hospital staff to be interviewed. Primary data was collected through a SERVEQUAL objectively structured questionnaires. The questionnaire was self-administered but with research assistants available to assist patients who were unable to fill them on their own. Structured questionnaires were used to collect the required information from the study population (Cooper, 2003). The questionnaire was divided into two sections; the first section was covering the background information of the respondents while the second section will covered the objectives of the study. Specifically for the questionnaire targeting hospital staff, the socio-demographic section had questions pertaining to their background (age, level of education and gender), there years of experience both at work and with the hospital and to the best of their knowledge their idea of funding streams that supported the hospital.

Table 1: Measurement of variables

Variable	Indicators	Measurement	Section in the Questionnaire
Quality Services	Tangibility Reliability Responsiveness Assurance Empathy	5 Item Likert scale Data information (Nominal)	Part B
Equity Financing	Ex- Chequer Out of Pocket Payments Insurance	5 Item Likert scale Data information(Ordinal)	Part C

Source: Survey Data, (2017)

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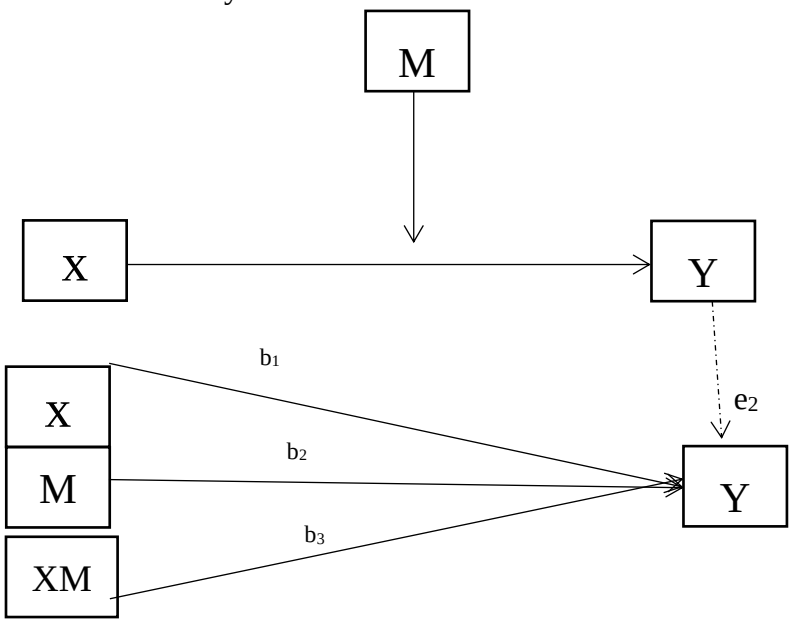
3.2 Data Analysis Methods and Modeling

In order to examine the effect of each financial strategy on the hospital service quality, linear, multiple regression and PROCESS Version 3.4 (Hayes model 1) were used, with a financing strategy (debt, equity and network) as the independent variable x and hospital service quality (SERVEQUAL gap score) as the dependent variable y. The strength of each of the models was examined by looking at the R^2 change. An analysis of variance (ANOVA) test was run to test whether the models were significantly better at predicting service quality than using the mean as a better guess. Interpretations were made by examining the F (f-ratio) and the P-value associated with them. The regression coefficients were examined for interpretation of the magnitude of contribution the independent variable had on hospital service quality and the direction of service quality (either negative or positive).

As discussed in the results chapter hospital bed capacity was picked as the main moderating institutional characteristics while the size of the hospital and the age of the hospital were picked as the control variables. Hospital bed capacity and type of hospital were selected as the main effect variables because they most often appear to be mentioned as being related to quality of services in the hospitals. A statistically significant rise of predictive ability of the model was interpreted to have significant moderation between the main effect variables and financing strategies on the service quality of a hospital. Only significant results were subjected to PROCESS moderation analysis. PROCESS version 3.4 developed by Prof. Andrew F. Hayes reviewed by Hayes, (2017) was employed. A key output of the analysis was the interaction plots from data on conditional effect of x and y.



Conditional effect of X and Y = $b_1 + b_1M$

(Hayes, 2014).

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4.1 Findings

The findings on the financing strategies on delivery of quality healthcare services in level 4 to level 6 hospitals as well as the moderating effects of hospital characteristics (bed capacity) on the relationship between financing strategies on the delivery of quality healthcare services in hospitals in Kenya. This chapter opens with a section on the demographic description of participants and institutions involved in data collection. This was followed by reporting of data pertaining to the research objectives posed in this study, factor analysis, regression analysis and the results on moderation effect.

4.2 Descriptive Results

The study adopted an 'average score approach' to calculate respondents' total score (Osborne, 2013). This approach aggregates and calculates only those items answered by the respondents (e.g., if five items are used to measure a scale and one item is missing, the syntax calculates the average of the four items answered). Therefore, it provides an accurate total score for each construct by eliminating the missing responses. The syntax used was "MEAN#.X (a,b,c…)" where X is the minimum number of items with a valid score. In order to use this method, a majority of items must be answered (Osborne, 2013). Table 1 shows the results on data transformation. From the findings, service quality had the highest mean (3.73) followed by followed by equity financing (3.22) while, Hospital bed capacity had mean of (2.33). The standard deviations for the variables were less than 1 except Hospital bed capacity indicating less variation in the responses. Finally, all independent variables and the dependent variables were normally distributed as shown in Table 2 below.

Table 2: Data Transformation

n=216	Min	Max	Mean	Std. Deviation	Skewness	Kurtosis
Service Quality	1.46	4.88	3.73	0.63	-1.98	5.23
Equity Financing	1.31	4.45	3.22	0.59	-1.38	2.87
Hospital bed capacity	1.00	5.00	2.33	1.17	0.49	-0.82

Source: Research Data, (2017)

Hayes Model 1: for Testing Moderating Effect

The result presented by table 3, shows that 9.1% was explained by the moderation effect of hospital bed capacity between equity financing and service quality (R-sq change =.091). From findings showed that moderation of hospital bed capacity has a significant effect on relationship between equity financing and service quality (β= 0.348, p=0.00). The moderation effect was also confirmed by bootstrapping upper and lower level of confidence with no zero in between (BootLLCI= 0.201, BootULCI= 0.496).

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Table 3: Moderating Effect of Bed Capacity on Relationship between Equity Financing and Service Quality

Model : 1 Y : ZService X : ZEquityF W : ZBedcapa
OUTCOME VARIABLE: ZService

Model Summary

R	R-sq	MSE	F	df1	df2	p
0.329	0.108	0.905	8.553	3	212	0.000

Model

	Coeff	Se	T	P	LLCI	ULCI
Constant	0.000	0.066	0.000	1.000	-0.130	0.130
ZEquityF	0.030	0.069	0.435	0.664	-0.105	0.165
ZBedcapa	0.061	0.067	0.904	0.367	-0.072	0.192
Int_1	0.348	0.075	4.645	0.000	0.201	0.496

Product terms key:
Int_1 : ZEquityF x ZBedcapa

Test(s) of highest order unconditional interaction(s):

	R2-chng	F	df1	df2	p
X*W	0.091	21.5781	1	212	0.000

Conditional effects of the focal predictor at values of the moderator(s):

ZBedcapa	Effect	Se	T	P	LLCI	ULCI
-1.141	-0.368	0.095	-3.882	0.000	-0.554	-0.181
-0.282	-0.069	0.066	-1.034	0.302	-0.199	0.062
1.435	0.530	0.142	3.736	0.000	0.250	0.809

Level of confidence for all confidence intervals in output: 95.0000
W values in conditional tables are the 16th, 50th, and 84th percentiles.

Source: Research Data, (2017)

The Mod graphs presented in Figure 1 respectively fulfilled the condition that for interaction effects to be significant, the graphs should not be parallel but have different slopes or gradient (Jose, 2008). The graphs were used to test whether facility type moderates the effect of predictor variables on service quality. The interaction effect of hospital bed and debt financing on service quality were assessed at low and high levels. However, the relationship between the equity financing strategies and service quality was moderated by hospital bed, hence presented graphically. Therefore, the results in Table 1 were also confirmed by plotting them in a Modgraph.

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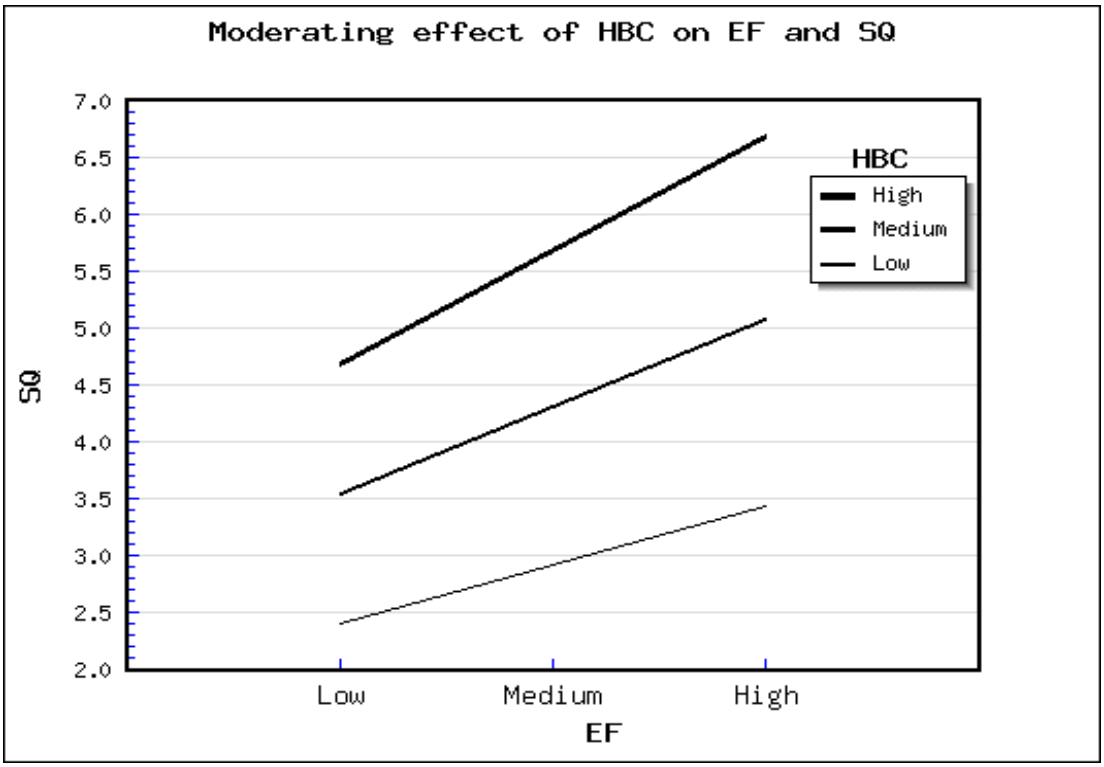

Figure 1: Moderating Effect of HBC on EF and SQ

Source: Research Data, (2017)

For descriptive purposes, this study plotted predicted equity financing against service quality, separately for low and high levels of Hospital bed capacity (Fig.1). Simple slope tests indicated that for low Hospital bed capacity, higher levels of equity financing were associated with higher-level of service quality.

The results presented in Table below 4 indicated the summary of both multiple and hierarchical regression models. Thus, the table shows (R^2) and Δ in (R^2) for both main and interaction effects as well as the decision on the formulated hypothesis.

Table 4: Summary of Hypotheses Testing Results

Hypothesis Formulated	Beta (β)	$\mathbf{R^2\Delta}$	Decision
Ho_{5a}: Bed capacity does not moderate the relationship between equity financing and service quality	.348	.091	Moderated

Source: Research Data, (2017)

5.1 Conclusion and Recommendations

The study concludes hospital with high bed capacity are able to generate more equity financing, through user charges through out-of-pocket (OOP), Ex-chequer, Out of Pocket and NHIF and service quality. The study also concluded that efficient financing strategies is very important and also one that generates a relatively large amount of funding and thus obviates the need for multiple funding strategies, with each generating only a limited amount of funds.

From the findings the study, it is recommended that the government should consider sizable hospitals to leverage equity financing at the same time improve financial management in healthcare service organizations in order to promote other functions that contribute to service delivery. The study has identified efficient health care financing strategies to be used if Kenya to achieve universal health coverage. Replacement of out of Pockets with more equitable modes of financing to improve accessibility of healthcare by the poor. The study also recommends that Hospitals management should ensure that financing strategies adopted is for long-term stability and potential for generating revenue. If the revenue generated by a financing strategies is subject to considerable and frequent fluctuations, the strategies cannot be regarded as reliable and is likely to be replaced by financing strategies that are more predictable in the medium to long term such as insurance. The study recommend to the Hospitals management that its financing strategies should be able maintain its level of funding in the long term and to expand its level of funding over time as the need for health care grows.

The study contributes to the theory on how different financing strategies (equity financing) and service quality in hospitals relate. The study findings that equity financing positively enhance service delivery in hospitals support financing theories such as Modiglani Miller Theory, The Tradeoff Theory, Pecking Order Theory and Finance Models which most of them indicate that financing decision impact on firm operation performance which affect quality of service offered. In addition, the study validates and confirm theoretical proposition that hospital bed capacity affects the relationship between financing strategies (equity financing) and service quality in hospitals.

The researcher suggests a need for a study on Healthcare reforms on other aspect like the ideal size of hospitals, the best model of hospital management among others as the researcher found that Healthcare financing reforms on their own cannot solve all the problems of the healthcare systems. There is need to be supplemented by reforms in other related areas necessary in enhancing provision of affordable quality health care.

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